The ways in which international comparisons can contribute to our understanding of the minor mental disorders differ considerably from those in which they contribute to the major ones. With the latter we have been dealing with fairly distinct syndromes and fairly uniform methods of identifying them in a population, even though these methods do not operate everywhere and though some ambiguity remains. Much could therefore be done in the way of comparing incidence rates or considering cultural variations in the characteristics of those who display the core syndrome, both in historical sequence and across contemporary societies. With the neuroses and other minor disorders there has been no such agreement either past or present. Prior to 1900 the term neurosis carried mainly the neurological connotation given it by its inventor, Cullen, in 1784, so that one found it embracing not just hysteria and the neurasthenias but Parkinsonism and chorea; and even the classic term hysteria was not applied in any uniform fashion, for instance being used for males by some writers but not by others. Today Cullen's organic concept of neurosis persists in some Pavlovian schools, but even if one ignores the latter and considers the term to apply only to conditions in which there is no evidence of a relevant organic disorder, i.e., psychoneuroses, one finds that there are markedly different ways in which it is employed, so that different interpretations need to be applied to reports which, if they had dealt with the psychoses, could probably have been given a uniform interpretation. If this were merely a problem of nosology, i.e., a problem of deciding which clinical pictures to include under each heading, we might be able to circumvent it by focusing on precise syndromes, but it was one of the early discoveries of psychoanalysis that when one syndrome was "cured" — for instance by hypnosis — a different one would appear. Viewing superficially different syndromes as distinct entities thus becomes of doubtful value, and it seems much better that we should attempt to compare whole classes or categories of syndromes, perhaps only between those societies in which a uniform nosology reigns. However, although the latter is sound in principle, one is still liable to find that the criteria whereby this nosology is applied vary considerably both within and between these societies.

What is regarded as a neurosis in Western societies today differs significantly depending on the category of professional involved and the setting in which he is working, the main relevant categories being general physician, private or clinic psychiatrist, psychoanalyst, and sociologist. For the general medical practitioner and internist the term neurosis may merely imply that there has been no success in attributing the patient's complaints to a definite somatic source; and a prevalence survey using general practitioners is liable to bring to the fore the somatizations but not those syndromes whose features are wholly psychic. For the psychoanalyst a conceptually sounder definition is likely to reign, perhaps that given by Fenichel [183, p18],
but the social selection that determines which patients reach a psychoanalyst is so biased that we cannot take the patients whom he sees as representative of those in the general population. The psychiatrist may also use a conceptually sound definition of neurosis and he usually sees a broader sample of the public; but it has been shown that some psychiatrists apply the term to anyone seeking psychotherapy for whom a more precise diagnosis is not apparent, and neurotics who do not seek psychotherapy are unlikely to be known to them. Finally, if our sampling of neurotics is through a household mental health survey, something most often guided by sociologists, we will find well-represented, persons who are able to directly verbalize their symptoms in response to the questions which the surveyor poses, but not those whose symptoms fall outside the range enquired into (which is usually restricted) or those who cannot verbalize their problems. Moreover, cultural groups can vary considerably in response style, and household surveys can yield deceptive cross-cultural comparisons, as was found in the Midtown Manhattan Survey [583] whose small Puerto Rican sample, as was noted earlier (p 52), apparently contained no healthy person.

It is thus from quite restricted sources such as an army (see Table 5.1) that we can expect to get reasonable, quantitative, data on the neuroses, and even from such a source there are important categories of disorder that are liable to be missed, for instance the obsessional. Rather than pursue data on incidence, therefore, it is better for Comparative Psychiatry to undertake other types of enquiry regarding the neuroses. One such alternative objective is the study of syndromes which are common in a very few cultures and rare in all others – the so-called culture-bound syndromes. By exploring why these should arise so much more in some societies than in others, we may be able to uncover new clues to the etiology and mechanisms of the neuroses.

Another possible objective is the testing of what might be called the social relativity theory of the neuroses, i.e., the idea that neuroses are an internal reflection of external – social – conflicts, varying with the latter and having no essential character of their own. It was probably the Scottish psychiatrist, R.D. Gillespie, best known for his textbook with Henderson [255], who enunciated this theory most clearly when he wrote that “psychoneuroses are in the ultimate analysis social disorders of individuals. They are symptomatic of a disturbance of social relationships mentally ‘introjected’.” [218, p36]. More recent authors who have written in a similar vein are R.D. Laing [330] and Thomas Scheff [537]. Gillespie did not mean, of course, that predisposing factors were irrelevant – he wrote considerably on constitutional predisposition – or that precipitating events were all merely an aspect of social conflicts. However, he does appear to have meant that the nature and symptomatology of the neuroses depend less on events in infancy or on recent traumata than on the character of the social conflicts around the patient and the conventions which the society employs for controlling such conflicts.

That social relativity theory is one which Comparative Psychiatry is particularly suited to test. We will therefore examine the stability of the neuroses first in relation to an apparently uniform and powerful precipitating factor, and then in relation to early childhood experiences in different societies, asking to what extent contemporary social conflicts appear to be affecting the symptomatology.